CITY OF LONG BEACH

RESPIRATOR EVALUATION MEDICAL QUESTIONNAIRE

INSTRUCTIONS TO THE LICENSED HEALTH CARE PROFESSIONAL

1. Please review the medical questionnaire and/or perform the set of tests indicated below for this employee.
2. The results of the required testing must be recorded on pages 7 and 8.
3. Please review the questionnaire previously completed by the employee.
4. This questionnaire and all medical findings must be retained in Occupational Health files.

MEDICAL EXAM COMPONENTS	INITIAL	ANNUAL
Frequency of medical examination	**Upon hiring or upon inclusion in the RPP**	
Medical Questionnaire	_	_
Physician review of questionnaire	_	_
Optional medical evaluation based upon physician review of questionnaire.		_
Height	_	D
Weight	_	D
Pulse	_	D
Blood Pressure	_	D
Cardiac	_	D
Respiratory	_	D
Ear, nose, throat	_	D
Pulmonary Function Test	_	D
Chest X-ray	_	D
EKG	_	D

D = Depending upon physicians review of the medical questionnaire.
RPP = Respiratory Protection Program

CITY OF LONG BEACH

RESPIRATOR EVALUATION MEDICAL QUESTIONNAIRE

INSTRUCTIONS TO EMPLOYEE

Your supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisors must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to Occupational Health or delegate physician who will review it.

Please answer all questions in this booklet (pages 2 to 6) to the best of your knowledge. This questionnaire is used to gather information about your health and physical condition both now and in the past. This information will be used to determine if you can safely use a respirator.

PLEASE PRINT LEGIBLY AND COMPLETELY FILL-OUT BELOW				
LAST NAME	FIRST NAME			M.I.
DEPARTMENT	BUREAU	JOB TITLE	WORK LOCATION	TIME W/CITY Yrs.
HOME ADDRESS				
CITY OR TOWN	STATE	ZIP CODE		
AREA CODE AND HOME PHONE NUMBER	DATE OF BIRTH	AGE		
SOCIAL SECURITY NUMBER	GENDER (Please circle) ☐ MALE / ☐ FEMALE			

PLEASE BE SURE THE ABOVE INFORMATION IS COMPLETE AND CORRECT

Consent

I have read or have had explained to me and understand the instructions for completing this questionnaire. All responses given are complete and accurate.

I understand that the purpose of this testing program is to screen for health problems potentially affecting respirator use, that it does not take the place of full examination by my health professional, and that it should not interrupt any regular pattern of care now being conducted by my health professional.

PLEASE SIGN IN INK _____ _____

Signature of participant Date

PLEASE READ AND FOLLOW THESE INSTRUCTIONS CAREFULLY BEFORE ARRIVING FOR YOUR APPOINTMENT.

PERSONAL (SECTION 1)

Has your employer told you how to contact the healthcare professional who will review this questionnaire?

☐ Yes ☐ No

What is the phone number at which you can be reached by the healthcare professional who reviews this questionnaire (include area codes):

(_____) _____

What is the best time to reach you?

From: _____ AM/PM TO: _____ AM/PM

Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?

☐ Yes ☐ No

Please indicate your tobacco use.

☐ Currently smoke tobacco or have smoked tobacco in the last month

Please provide your correct height and weight (without shoes).

HEIGHT: Feet _____ Inches _____

WEIGHT: Pounds _____

OCCUPATIONAL (SECTION 2)

At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, dust) or have you come into skin contact with hazardous chemicals?

☐ Yes ☐ No

Have you ever worked with any of the materials, or under any of the conditions, listed below:

Asbestos	☐ Yes	☐ No
Silica (e.g., sandblasting)	☐ Yes	☐ No
Coal (e.g., mining)	☐ Yes	☐ No
Grinding or welding of the following materials:		
Tungsten/Cobalt	☐ Yes	☐ No
Beryllium	☐ Yes	☐ No
Aluminum	☐ Yes	☐ No
Iron	☐ Yes	☐ No
Tin	☐ Yes	☐ No
Dusty Environments	☐ Yes	☐ No
Any other hazardous exposures	☐ Yes	☐ No

If "yes," describe these exposures: _____

List any second jobs or side businesses you have:

List your previous occupations:

List your current and previous hobbies:

Have you ever been in the military service?	☐ Yes	☐ No
If "yes," were you exposed to biological or chemical agents (either in training or combat?	☐ Yes	☐ No
Have you ever worked on a HAZMAT team?	☐ Yes	☐ No
Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?	☐ Yes	☐ No

If "yes," describe this protective clothing and/or equipment

Will you be working under conditions where temperatures exceed 77°F?	☐ Yes ☐ Don't Know	☐ No
Will you be working under humid conditions?	☐ Yes ☐ Don't Know	☐ No

Describe the work you will be doing while you are using your respirator(s): _____

Describe any special hazardous conditions you might encounter when you are using your respirator(s). (For example, confined spaces, life-threatening gases, high altitude):_____

Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-

being of others (e.g., rescue, security): _____

_____

_____

_____ ☐ Don't Know

RESPIRATOR USE (SECTION 3)

Have you ever worn a respirator in the past?

☐ Yes ☐ No

What type of respirator did you or will you wear? (mark all that apply)

☐ Don't Know

Disposable particulate filter mask (N,P,R, non-cartridge dust mask)	☐ Now	☐ Past
Half face cartridge respirator	☐ Now	☐ Past
Full face cartridge respirator	☐ Now	☐ Past
Powered air purifying respirator	☐ Now	☐ Past
Supplied air (airline) respirator	☐ Now	☐ Past
Self contained breathing apparatus (SCBA)	☐ Now	☐ Past

If you've ever used a respirator, have you ever had any of the following problems while wearing a respirator? (*Omit if you have never used a respirator.)*

Eye irritation	☐ Yes	☐ No
Skin allergies or rashes	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
General weakness or fatigue	☐ Yes	☐ No
Any other problem that interfered with your use of a respirator	☐ Yes	☐ No

HEART, LUNGS, AND OTHER BODY SYSTEMS (SECTION 4)

Have you ever had any of the following cardiovascular or heart problems?

Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina (chest pain)	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Swelling in your legs or feet (not caused by standing or walking)	☐ Yes	☐ No
Heart arrhythmia	☐ Yes	☐ No
Any other heart problem that you have been told about	☐ Yes	☐ No

Have you ever had any of the following pulmonary or lung problems?

Asbestosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Silicosis	☐ Yes	☐ No
Lung cancer	☐ Yes	☐ No
Broken ribs	☐ Yes	☐ No
Pneumothorax (collapsed lung)	☐ Yes	☐ No
Any chest injuries or surgeries	☐ Yes	☐ No
Any other lung problem that you've been told about?	☐ Yes	☐ No
Have you ever had seizures (fits or sudden loss of consciousness)?	☐ Yes	☐ No
Have you ever been told you had diabetes (sugar disease)?	☐ Yes	☐ No
Have you ever had allergic reactions that interfere with your breathing?	☐ Yes	☐ No
Have you ever experienced claustrophobia (fear of closed-in places)?	☐ Yes	☐ No
Have you ever had trouble smelling odors?	☐ Yes	☐ No

Have you ever had any of the following pulmonary, cardio-vascular, lung or heart symptoms?

Shortness of breath	☐ Yes	☐ No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ Yes	☐ No
Shortness of breath when walking with other people at an ordinary pace on level ground	☐ Yes	☐ No
Have to stop for breath when walking at your own pace on level ground	☐ Yes	☐ No
Shortness of breath when washing or dressing yourself	☐ Yes	☐ No
Shortness of breath that interferes with your job	☐ Yes	☐ No

Have you had any of the following conditions within the past year? Explain any yes answers below.

Coughing that produces phlegm (thick sputum)	☐ Yes	☐ No

phlegm (thick sputum)

Coughing that occurs mostly when you are lying down	☐ Yes	☐ No
Coughing up blood in the last month	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Wheezing that interferes with your job	☐ Yes	☐ No
Chest pain when you breathe deeply	☐ Yes	☐ No
Coughing that wakes you early in the morning	☐ Yes	☐ No
Any other symptoms that you think may be related to lung problems	☐ Yes	☐ No

_____

_____

_____

_____

Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest.	☐ Yes	☐ No
Pain or tightness in your chest during physical activity	☐ Yes	☐ No
Pain or tightness in your chest that interferes with your job	☐ Yes	☐ No
In the past two years, have you noticed your heart skipping or missing a beat?	☐ Yes	☐ No
Heartburn or indigestion that is not related to eating	☐ Yes	☐ No
Any other symptoms that you think might be related to heart or circulation problems	☐ Yes	☐ No

MEDICAL HISTORY (SECTION 5)

Do you take any of the following medications on a daily basis:

Heart medicine	☐ Yes	☐ No
Blood pressure medicine	☐ Yes	☐ No
Medicine for seizures	☐ Yes	☐ No
Allergy/Asthma medications	☐ Yes	☐ No
Diabetes/Elevated Blood Sugar	☐ Yes	☐ No

FULL FACE OR SCBA RESPIRATOR USERS ONLY

The following questions must be answered by every employee who has been selected to use either a full-face piece respirator or Air Supply Respirator (Self-Contained Breathing Apparatus [SCBA] or air line). For employees who have been selected to use other types of respirators, answering the following questions is voluntary.

Have you ever lost vision in either eye (temporarily or permanently)

☐ Yes ☐ No

Do you currently have any of the following vision problems?

Wear contact lenses	☐ Yes	☐ No
Wear glasses	☐ Yes	☐ No
Color blind	☐ Yes	☐ No
Any other eye or vision problem	☐ Yes	☐ No

Have you ever had an injury to your ears, including a broken ear drum?

☐ Yes ☐ No

Do you currently have any of the following hearing problems?

Difficulty hearing	☐ Yes	☐ No
Wear a hearing aid	☐ Yes	☐ No
Any other hearing or ear problem	☐ Yes	☐ No

Have you ever had a back injury?	☐ Yes	☐ No

Do you currently have any of the following muscle or skeletal problems?

Weakness in any of your arms, hands, legs or feet	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Difficulty fully moving your arms and legs	☐ Yes	☐ No
Pain or stiffness when you lean forward or backward at the waist	☐ Yes	☐ No
Difficulty fully moving your head up or down	☐ Yes	☐ No
Difficulty fully moving your head side to side	☐ Yes	☐ No
Difficulty bending at your knees	☐ Yes	☐ No
Difficulty squatting to the ground	☐ Yes	☐ No
Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ Yes	☐ No
Any other muscle or skeletal problems that might interfere with using a respirator	☐ Yes	☐ No

STOP!

PHYSICIAN TO FILL OUT FOLLOWING SECTIONS.

PHYSICAL EXAMINATION AND SUPPORTING STUDIES

(PLEASE INITIAL ON AUTHORIZATION FORM WHEN COMPLETED)

HEIGHT	WEIGHT	TEMP	BLOOD PRESSURE	PULSE (Resting)
_____ inches	_____ lbs.	_____ ΞF	__/_____	_____/min.

SPIROMETRY			
FEV_1_____ Observed Vol.	_____ FVC	Observed Vol.	FEV_1 _____% FVC
FEV_1 _____ % Pred.	_____ FVC	% Pred.	

EKG (If marked YES on Exam Checklist)		CHEST X-RAY (If marked YES on Exam Checklist)	
☐ Normal	☐ Abnormal	☐ Normal	☐ Abnormal

COMMENTS: _____

_____

MEDICAL EXAMINATION

CHECKLIST	NORMAL	ABNORMAL	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
HANDS/SKIN			
HAIR	☐	☐	
SKIN COLOR/TEXTURE	☐	☐	
NAILS	☐	☐	
HEAD/EYES/EARS/NOSE/THROAT/MOUTH			
CONFIGURATION	☐	☐	
LIDS CONJ/SCLERA	☐	☐	
PUPILS/FUNDI/EOM	☐	☐	
PINNA/CNALS/TM	☐	☐	
NASAL SEPTUM/MUCOSA	☐	☐	
TEETH/GUMS/TONGUE/PALATE	☐	☐	
NERVOUS SYSTEM			
CN	☐	☐	
MOTOR	☐	☐	
SENSORY	☐	☐	
CEREBELLAR	☐	☐	
REFLEXES	☐	☐	
NECK/NODES			
BRUIT	☐	☐	
ROM	☐	☐	
MUSCLE STRENGTH	☐	☐	
THYROID	☐	☐	
NECK NODES	☐	☐	
INGUINAL/AXILLARY NODES	☐	☐	

CHECKLIST	NORMAL	ABNORMAL	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
CHEST/LUNGS			
SHAPE/SYMMETRY	☐	☐	
DIAPHRAGMATIC EXCURSION	☐	☐	
PERCUSSION	☐	☐	
AUSCULTATION	☐	☐	
CARDIOVASCULAR			
CAROTIDS	☐	☐	
NECK VEINS/PULSES	☐	☐	
HEART SOUNDS (MURMURS)	☐	☐	
HEART SIZE	☐	☐	
GASTRO/INTESTINAL			
LIVER			
SPLEEN	☐	☐	
MASSES	☐	☐	
TENDERNESS	☐	☐	
SCARS	☐	☐	
HERNIA	☐	☐	
MUSCULOSKELETAL/EXTREMITIES			
SPINAL ALIGNMENT	☐	☐	
EXTREMITIES	☐	☐	
(EDEMA, VARICOSITIES)	☐	☐	
JOINTS	☐	☐	
ROM	☐	☐	

COMMENTS:

EXAMINING PHYSICIAN (PRINT)	PHYSIAN'S SIGNATURE	DATE

EXAMINATION CHECKLIST

☐ HISTORY FORM	☐ BLOOD TEST
☐ VITAL SIGNS	☐ URINALYSIS
☐ EXAM FORM	☐ CHEST X-RAY
☐ AUDIOGRAM	☐ EKG
☐ PFT	☐ OTHER _____

INSTRUCTIONS FOR THE PHYSICIAN / CLINICIAN

1. The results of the required testing must be recorded on pages 7 and 8 .
2. Please be sure to note EKG and chest x-ray readings of NORMAL or ABNORMAL on page 8 if *required for this exam.*
3. Please review any YES answers ONLY for questions on pages 2 to 6 of this booklet. You are not required to review the other history questions.

Questions? Call Occupational Health (562) 570-4053